FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025130

Facility Name: CARRIER MILLS NURSING HOME

Address: 6789 ROUTE 45, P. O. BOX 68 (Number) CARRIER MILLS (City) 62917 (Zip Code)

County: SALINE

Telephone Number: (618) 994-2323 **Fax #** (618) 994-4082

IDPA ID Number: 37-1077294001

Date of Initial License for Current Owners: JAN. 1, 1979

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: WILLIAM H. MOORMAN **Telephone Number:** (618) 993-2647

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) WILLIAM H. MOORMAN, CPA, PARTNER
(Firm Name & Address) GRAY HUNTER STENN LLP, P. O. BOX 1728, MARION, IL 62959
(Telephone) (618) 993-2647 Fax # (618) 993-3981

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	443		2,815	3,258	8
9	SNF/PED					9
10	ICF	18,991	6,823		25,814	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,434	6,823	2,815	29,072	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.23%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1968

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/29/1978 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2,815

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	123,135	13,362	6,312	142,809		142,809		142,809			1
2	Food Purchase		129,443		129,443		129,443		129,443			2
3	Housekeeping	168,982	14,822		183,804		183,804		183,804			3
4	Laundry	48,040	15,062		63,102		63,102	133	63,235			4
5	Heat and Other Utilities			68,424	68,424		68,424	445	68,869			5
6	Maintenance	24,382		39,130	63,512		63,512	1,597	65,109			6
7	Other (specify):* SALES TAX			2,722	2,722		2,722	(2,722)				7
8	**TOTAL General Services**	364,539	172,689	116,588	653,816		653,816	(547)	653,269			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	882,460	165,891	1,302	1,049,653		1,049,653		1,049,653			10
10a	Therapy	50,987		48,655	99,642		99,642		99,642			10a
11	Activities	28,631	1,876	1,080	31,587		31,587		31,587			11
12	Social Services	16,899		1,080	17,979		17,979		17,979			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	978,977	167,767	55,717	1,202,461		1,202,461		1,202,461			16
	C. General Administration											
17	Administrative	49,662			49,662		49,662	152,171	201,833			17
18	Directors Fees											18
19	Professional Services			222,291	222,291		222,291	(197,929)	24,362			19
20	Dues, Fees, Subscriptions & Promotions			14,986	14,986		14,986	(6,774)	8,212			20
21	Clerical & General Office Expenses	26,444	19,323	10,493	56,260		56,260	16,150	72,410			21
22	Employee Benefits & Payroll Taxes			297,300	297,300		297,300	5,540	302,840			22
23	Inservice Training & Education			646	646		646		646			23
24	Travel and Seminar			4,113	4,113		4,113	161	4,274			24
25	Other Admin. Staff Transportation							953	953			25
26	Insurance-Prop.Liab.Malpractice			46,722	46,722		46,722	952	47,674			26
27	Other (specify):* ILREPLACE TAX			147	147		147	(147)				27
28	**TOTAL General Administration**	76,106	19,323	596,698	692,127		692,127	(28,923)	663,204			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,419,622	359,779	769,003	2,548,404		2,548,404	(29,470)	2,518,934			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CARRIER MILLS NURSING HOME #0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			5,052	5,052		5,052	58,859	63,911			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							41,057	41,057			32
33	Real Estate Taxes			50,900	50,900		50,900	359	51,259			33
34	Rent-Facility & Grounds			152,400	152,400		152,400	(152,400)				34
35	Rent-Equipment & Vehicles			5,881	5,881		5,881		5,881			35
36	Other (specify):* PENALTY			5,600	5,600		5,600	(5,600)				36
37	**TOTAL Ownership**			219,833	219,833		219,833	(57,725)	162,108			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			54,352	54,352		54,352		54,352			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,419,622	359,779	1,043,188	2,822,589		2,822,589	(87,195)	2,735,394			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,892	V-30		9
10	Interest and Other Investment Income	(896)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,722)	V-07		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,600)	V-36		18
19	Entertainment				19
20	Contributions	(1,344)	V-20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,795)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(147)	V-27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,925)	V-20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 1,463		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(88,658)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (88,658)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (87,195)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

CARRIER MILLS NURSING HOME

ID# 0025130

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(16,775)	0	0	0	0	0	0	0	0	0	(16,775)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(16,775)	0	0	0	0	0	0	0	0	0	(16,775)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(16,775)	0	0	0	0	0	0	0	0	0	(16,775)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	38,564	0	0	0	0	0	0	0	0	0	38,564	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	41,953	0	0	0	0	0	0	0	0	0	41,953	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(152,400)	0	0	0	0	0	0	0	0	0	(152,400)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(71,883)	0	0	0	0	0	0	0	0	0	(71,883)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(88,658)	0	0	0	0	0	0	0	0	0	(88,658)	45

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROGER D. HERRIN	62%	SALINE CARE CENTER	HARRISBURG, IL	CARRIER MILLS		
GROVER S. SLOAN	17%	SEVERIN INTERMEDIATE CARE	BENTON, IL	NURSING HOME		
ALICE STALLINGS	11%			LAND TRUST	CARRIER MILLS, IL	LAND TRUST
PENNY SISK	10%			RDK MGMT., INC.	HARRISBURG, IL	MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	PROFESSIONAL SERVICES	$ 199,036	RDK MANAGEMENT, INC (SEE ATTACHED SCHEDULE)		$ 182,261	$ (16,775)	1
2	V	30	DEPRECIATION		CARRIER MILLS NURSING HOME LAND TRUST		38,564	38,564	2
3	V	32	INTEREST		CARRIER MILLS NURSING HOME LAND TRUST		41,515	41,515	3
4	V	32	LOAN FEE EXPENSE		CARRIER MILLS NURSING HOME LAND TRUST		438	438	4
5	V	34	RENT	152,400	CARRIER MILLS NURSING HOME LAND TRUST			(152,400)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 351,436			$ 262,778	$ * (88,658)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROGER D. HERRIN	STOCKHOLDER	MANAGER	62.00	367,006	20	29.00	MGMT FEE	$ 152,171	17-7	1
2	GROVER S. SLOAN	STOCKHOLDER	DOCTOR	17.00							2
3	ALLICE STALLINGS	STOCKHOLDER	ADMINISTRATO	11.00	45,616	VARIOUS	VARIOUS	SALARY	17,385	17-1	3
4	"	"	"			VARIOUS	VARIOUS	SALARY	1,707	21-7	4
5	PENNY SISK	STOCKHOLDER	BOOKKEEPER	10.00	44,679	VARIOUS	VARIOUS	SALARY	8,500	21-1	5
6	"	"	"			VARIOUS	VARIOUS	SALARY	9,611	21-7	6
7											7
8											8
9	*SEE ATTACHED SCHEDULE										9
10											10
11											11
12											12
13								TOTAL	$ 189,374		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	UNION PLANTERS, N.A.		X	REFINANCE CONSTRUCTIO	$12,000.00	12/10/01	$ 1,470,000	$ 1,175,561	03/15/15	0.0425	$ 41,515	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DR. ROGER HERRIN	X		WORKING CAPITAL	SINGLE PAY	06/08/89	2,895	2,895	DEMAND	0.1000		6
7	DR. ROGER HERRIN	X		WORKING CAPITAL	SINGLE PAY	10/29/04	20,000	20,000	DEMAND			7
8												8
9	TOTAL Facility Related				$12,000.00		$ 1,492,895	$ 1,198,456			$ 41,515	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,492,895	$ 1,198,456			$ 41,515	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	47,163	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	49,857	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,694	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	48,565	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	51,259	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	48,078	8
	2000	46,487	9
	2001	46,623	10
	2002	48,814	11
	2003	49,857	12

ACCRUAL BASED ON TAXES PAID IN 2004 FOR 2003.

(1) INCLUDES $359 FROM ALLOCATION OF MANAGEMENT EXPENSES.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARRIER MILLS NURSING HOME COUNTY SALINE

FACILITY IDPH LICENSE NUMBER 0025130

CONTACT PERSON REGARDING THIS REPORT WILLIAM H. MOORMAN

TELEPHONE (618) 993-2647 FAX #: (618) 993-3981

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-1-098-3	LAND AND BUILDINGS	$ 49,856.92	$ 49,856.92
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 49,856.92	$ 49,856.92

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,462 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SEE ATTACHED SCHEDULE	406,215		$ 27,689	1
2					2
3	TOTALS	406,215		$ 27,689	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1979	1968	$ 316,676	$	25	$	$	$ 316,676	4
5	57		1992	1992	1,200,956	38,564	25	48,038	9,474	577,897	5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF			1979	4,155		15			4,155	9
10	REDECORATING			1980	8,104		7			8,104	10
11	LANDSCAPING			1980	1,159		7			1,159	11
12	TILE			1983	225		5			225	12
13	LANDSCAPING			1983	220		5			220	13
14	IMPROVEMENTS			1985	450		20	21	21	450	14
15	IMPROVEMENTS - AIR CONDITIONER			1985	17,045	193	15		(193)	17,045	15
16	IMPROVEMENTS			1985	3,110		10			3,110	16
17	IMPROVEMENTS - AC COMPRESSOR/WATER HEATER			1986	1,772	92	15		(92)	1,772	17
18	IMPROVEMENTS - FLOORING/LANDSCAPING			1987	3,112	88	15		(88)	3,112	18
19	IMPROVEMENTS - REDECORATING			1988	1,153		10			1,153	19
20	CARPETS			1989	180		5			180	20
21	IMPROVEMENTS - WASHER/DRYER/BATHTUB			1993	32,837		10			32,837	21
22	IMPROVEMENTS - ALLOCATED SHEETS (1)			1993	31,929	828	30	1,064	236	11,209	22
23	IMPROVEMENTS - ROOF			1994	16,000	400	30	533	133	5,863	23
24	IMPROVEMENTS - ALLOCATED SHEETS (1)			1994	1,380	48	30	46	(2)	449	24
25	IMPROVEMENTS - ALLOCATED SHEETS (1)			1996	51	3	30	2	(1)	15	25
26	IMPROVEMENTS - TILE WORK			1997	6,682	576	30	223	(353)	1,784	26
27	IMPROVEMENTS - STORAGE BUILDING			1998	1,000	26	39	26		172	27
28	IMPROVEMENTS - ALLOCATED SHEETS (1)			1998	232	6	30	8	2	53	28
29	IMPROVEMENTS - ALLOCATED SHEETS (1)			2000	5,129	227	30	171	(56)	854	29
30	IMPROVEMENTS			2001	1,563		10	156	156	624	30
31	IMPROVEMENTS			2002	3,424	419	10	342	(77)	1,026	31
32											32
33											33
34											34
35	(1) ALLOCATION OF HOME OFFICE ASSETS - SEE SCHEDULE										35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,658,544	$ 41,470		$ 50,630	$ 9,160	$ 990,144	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 134,053	$ 1,790	$ 12,458	$ 10,668	10	$ 84,735	71
72	Current Year Purchases	8,228	3,849	823	(3,026)	10	823	72
73	Fully Depreciated Assets	390,285					390,285	73
74								74
75	TOTALS	$ 532,566	$ 5,639	$ 13,281	$ 7,642		$ 475,843	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TRAVEL	1995 MERCEDES 500 SL	1995	$ 24,574	$ 520	$	$ (520)	4	$ 24,574	76
77										77
78										78
79										79
80	TOTALS			$ 24,574	$ 520	$	$ (520)		$ 24,574	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,243,373	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 47,629	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 63,911	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,282	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,490,561	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CARRIER MILLS NURSING HOME LAND TRUST

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1968	42		$			3
4	Additions	1992	57	01/01/04	152,400	1	AS AGREED	4
5								5
6								6
7	TOTAL		99		$ 152,400 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/04
Ending 12/31/04

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,881 Description: MISC. EQUIPMENT
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (24,142)	$ (24,142)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	345,414	345,414	3
4	Supply Inventory (priced at COST)	1,618	1,618	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,276	17,276	6
7	Other Prepaid Expenses	12,998	12,998	7
8	Accounts Receivable (owners or related parties)	10,000	10,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 363,164	$ 363,164	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		24,748	13
14	Buildings, at Historical Cost		1,439,296	14
15	Leasehold Improvements, at Historical Cost	50,202	50,202	15
16	Equipment, at Historical Cost	457,554	640,063	16
17	Accumulated Depreciation (book methods)	(475,855)	(1,325,849)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe GOODWILL	1,000	1,000	22
23	Other(specify): UNAMORTIZED LOAN COSTS		5,800	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 32,901	$ 835,260	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 396,065	$ 1,198,424	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 42,051	$ 42,051	26
27	Officer's Accounts Payable	22,895	22,895	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,459	11,459	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,061	4,061	31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,857	49,857	32
33	Accrued Interest Payable		2,082	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED MANAGEMENT FEES	17,581	17,581	36
37	ACCRUED INSURANCE	24,352	24,352	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 172,256	$ 174,338	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	242,376	1,243,872	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 242,376	$ 1,243,872	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 414,632	$ 1,418,210	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (18,567)	$ (219,786)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 396,065	$ 1,198,424	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (26,582)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (26,582)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,015	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 8,015	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (18,567)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,850,783	1
2	Discounts and Allowances for all Levels	(21,075)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,829,708	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	896	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 896	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,830,604	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	653,816	31
32	Health Care	1,202,461	32
33	General Administration	692,127	33
	B. Capital Expense		
34	Ownership	219,833	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,822,589	40
41	**Income before Income Taxes (line 30 minus line 40)****	8,015	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 8,015	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,080	$ 48,731	$ 23.43	1
2	Assistant Director of Nursing	1,188	1,386	25,236	18.21	2
3	Registered Nurses	9,790	9,990	173,328	17.35	3
4	Licensed Practical Nurses	18,561	18,940	231,635	12.23	4
5	Nurse Aides & Orderlies	54,546	55,659	403,530	7.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,920	2,080	33,440	16.08	7
8	Rehab/Therapy Aides	1,763	1,937	17,547	9.06	8
9	Activity Director	1,787	1,925	14,112	7.33	9
10	Activity Assistants	2,029	2,092	14,519	6.94	10
11	Social Service Workers	2,081	2,475	16,899	6.83	11
12	Dietician					12
13	Food Service Supervisor	1,548	1,596	13,793	8.64	13
14	Head Cook	9,151	9,214	68,647	7.45	14
15	Cook Helpers/Assistants	5,771	6,011	40,695	6.77	15
16	Dishwashers					16
17	Maintenance Workers	1,890	1,969	24,382	12.38	17
18	Housekeepers	22,402	23,095	153,585	6.65	18
19	Laundry	7,480	7,711	48,040	6.23	19
20	Administrator	921	921	17,385	18.88	20
21	Assistant Administrator	1,920	2,080	32,277	15.52	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,413	3,593	26,444	7.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) ENVIRONMENT	1,752	1,908	15,397	8.07	33
34	TOTAL (lines 1 - 33)	151,833	156,662	$ 1,419,622 *	$ 9.06	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	156	$ 6,312	1-3	35
36	Medical Director	PRN	3,600	9-3	36
37	Medical Records Consultant	36	1,302	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	2,400	10a-3	39
40	Physical Therapy Consultant	197	14,240	10a-3	40
41	Occupational Therapy Consultant	694	22,300	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	89	3,497	10a-3	43
44	Activity Consultant	24	1,080	11-3	44
45	Social Service Consultant	24	1,080	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,268	$ 55,811		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ALICE STALLINGS	ADMINISTRATOR	11.00%	$ 17,385
ELSIE JOHNSON	ASST ADMINISTR	0.00%	32,277
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,662

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RDK MANAGEMENT, INC.		$
DR. ROGER HERRIN	MANAGEMENT FEES	199,036
GRAY HUNTER STENN, LLP	ACCOUNTING	12,702
ALTS, MELVOIN & GLASSER	ACCOUNTING	2,075
AMER. EXPRESS	ACCOUNTING	50
JFDM&F	LEGAL	2,978
DUANE MORRIS, LLP	LEGAL	5,000
THOMAS WOLF, JR.	LEGAL	450
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 222,291

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,824
Unemployment Compensation Insurance	23,086
FICA Taxes	112,556
Employee Health Insurance	16,420
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE LIFE INSURANCE	6,429
EMPLOYEE HEALTH BENEFITS	280
MISCELLANEOUS	29,705
MANAGEMENT ALLOCATION (1)	5,540
TOTAL (agree to Schedule V, line 22, col.8)	$ 302,840

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,015
Health Care Worker Background Check	608
(Indicate # of checks performed 50)	
IHCA DUES	2,303
DONATIONS	1,344
ADVERTISING	5,720
LICENSE & PERMITS	223
DUES & SUBSCRIPTIONS	783
MANAGEMENT ALLOC (SEE SCH)	290
Less: Public Relations Expense	(1,344)
Non-allowable advertising	(1,795)
Yellow page advertising	(3,925)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,212

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
DIETARY MANAGERS ASSOC	416
LIFE SAFETY	100
IHCA	196
Seminar Expense	
(SEE ATTACHED SCHEDULE)	3,562
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,274

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME **#** 0025130 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA DUES $2,303**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,627** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
CARRIER MILLS NURSING HOME LAND TRUST; #0025130; 01/01/83

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.